Section Analysis
SB 395

Introduction

SB 395 is a comprehensive effort to address health care issues facing Montanans. Specifically, the bill would:

- Increase the number of Montanans who have health insurance coverage,
- Help stabilize private insurance premiums by reducing providers' uncompensated care costs,
- Modernize the way Medicaid delivers health care services to its recipients to enhance the value taxpayers receive for the tax dollars spent on these services,
- Identify long- and short-term strategies to contain health care costs, and
- Encourage Medicaid beneficiaries to assume greater responsibility for their medical conditions and overall health care.

The following is a section-by-section analysis that explains in greater detail how these goals are achieved.

Section 1. Short title for sections 1 through 6: "Montana Health Care Reform Act"

Section 2. Legislative Findings and Intent. The intent of sections 1 through 5 is to enhance Montana's health care delivery system to ensure access to quality and affordable health care for all Montanans. To achieve this purpose, stakeholders must collaborate to:

- Increase the number of Montanans with health insurance coverage,
- Make the delivery of health care services more efficient and cost effective – greater value for tax dollars spent on Medicaid – by offering incentives to encourage providers to reach performance outcomes, improve coordination of care, reduce preventable hospital admissions, and explore reimbursement methodologies that promote quality of care and efficiencies.
- Contain health care costs by curbing wasteful spending, avoiding unnecessary use of health care services and reducing fraud.
- Assure an adequate supply of health care professionals.
- Provide incentives that result in Montanans taking greater responsibility for their personal health.
- Boost Montana's economy by reducing the costs of uncompensated care.
- Reduce cost-shifting that results from care provided to uninsured Montanans.
- Testing effectiveness of wellness incentives.

Section 3. Definitions.

Section 4. Review of Medicaid and health care delivery systems. The bill establishes a process to review implementation of a Medicaid or coverage expansion and recommend short-term and long-term ways to make the Medicaid and overall health care delivery system more efficient and cost-effective.

To achieve this, the bill requires the Department of Public Health and Human Services to create an advisory committee with up to 12 members. Members of the committee are to include health care providers, consumers and other parties in the way health care services are provided.

The advisory committee is charged with reviewing and making recommendations to DPHHS in several areas, including:

- Implementation of the Medicaid expansion, including the requirement to explore private contracting to provide coverage to the Medicaid expansion population.
- Short-term and long-term policy changes that would enhance coordination of care and make the health care system more efficient – e.g. medical homes, coordinated care organizations and incentives to meet measurable outcomes in the delivery of care.
- Reducing the shifting of unpaid medical costs to privately-insured Montanans.
- Reducing overuse of health care services and inappropriate use of emergency departments.
- Increasing availability of mental health services.
- Improving data sharing to identify patterns in the use of health care services across payment sources.

DPHHS will coordinate its activities and those of the advisory committee legislative committees working on similar issues. It also must file a final report with the Children, Families, Health and Human Services Interim Committee by August 15 in 2014 and 2016. The committee terminates on June 30, 2017.

Section 5. Medicaid wellness – i.e. chronic disease management – pilot. DPHHS is required to develop a wellness pilot project for adult Medicaid recipients to encourage them to meet certain targets for managing chronic diseases. The pilot would be conducted in up to five counties, one of which should have a significant Indian population.

Section 6. Short title for sections 6 through 8: "Montana Health Care Workforce Data Collection Act."

Section 7. Physician database. The bill would require the Board of Medical Examiners to collect demographic data about physicians, as well as data about their practice specialty and location. The purpose of this is to help identify potential physician shortage areas and strategies for physician recruitment and retention.

Section 8. Physician database. The section provides additional detail about the physician database.

Section 9. Benefit plan for Medicaid expansion. The bill requires DPHHS to pursue contracting with private vendors to provide or pay for services provided to the Medicaid expansion population. The bill suggests four ways this could be achieved:

- Use of a third-party administrator to operate the program as was done initially with the Children's Health Insurance Program,
- Contracting with a private insurer to provide all services rather than using the current fee-for-service system,
- Using Medicaid funds to purchase qualified health plans for the expansion population, and
- Incentives to allow individuals to purchase coverage through the health insurance exchange.

The bill does not limit DPHHS to pursuing one of these four options, and gives them the ability to pursue other options as they become available.

This section also requires the state to use the essential health benefit plan selected by Montana as the benefit package for the Medicaid expansion population – rather than the benefit plan for traditional Medicaid beneficiaries. The benefit package also would include cost-sharing requirements – i.e. co-payments and deductibles – as allowed by federal law.

This section also requires DPHHS to report to the Children, Families, Health and Human Services Interim Committee by August 15 each year about several factors, including:

- The number of persons determined to be eligible for Medicaid,
- The average cost of medical services provided to these individuals,
- The average length of time these individuals remained eligible for Medicaid,
- The total cost of providing services to Medicaid recipients, and
- The status of efforts by DPHHS to contract for providing or paying for Medicaid services.

Section 10. Education and Outreach. DPHHS would be required to initiate outreach activities that educate Montanans about their options for obtaining health insurance through the health insurance exchange and the Medicaid program.

Section 11. Management of Medicaid program. DPHHS would be required to immediately strengthen programs aimed at providing care more efficiently and cost-effectively and improve medical outcomes. This would include – but is not limited to – requiring DPHHS to:

- Establish patient-centered medical homes for Medicaid beneficiaries;
- Strengthening the Passport to Health program, under which care for Medicaid recipients is coordinated by primary care physicians;
- Strengthen efforts to reduce inappropriate use of emergency room and other services.
- Strengthen case management programs for Medicaid recipients; and

- Require recipients with a higher-than-average use of narcotics to enroll in a pain management clinic.

Section 12. Deposit of unexpended Medicaid funds. DPHHS would be required to deposit into the mitigation account (*see section 13*) any general fund appropriated for Medicaid services that is not spent 12 months after the close of the fiscal year for which it was appropriated.

Section 13. Medicaid expansion mitigation account. Medicaid expansion would result in significant savings in state general fund spending. (For example, beneficiaries of mental health services now funded entirely by state general fund would be eligible for Medicaid under the expansion.) These savings would be allocated to a special account to be used to help offset the state's future financial obligations for expanding Medicaid coverage. DPHHS would be required to identify potential savings.

Statutory 14. Nursing database. This section would establish a nursing workforce database to help create a statewide strategy for promoting development of a nursing workforce that meets health care needs of Montanans.

Section 15. Executive Director. This section adds workforce data collection to the responsibilities of the executive director of the Board of Nursing.

Section 16. Medicaid Eligibility Requirements. This section modifies Medicaid eligibility statutes to incorporate eligibility for the Medicaid expansion population.

Section 17. Application for Medicaid. This language was requested by DPHHS to clean-up current eligibility processing statutes.

Section 18. Eligibility determination. Additional clean-up of the statutory requirements for determining Medicaid eligibility.

Section 19. Definitions.

Section 20. Codification instructions.

Section 21. Coordination instructions. This section coordinates the Medicaid appropriation in HB 2 to include transfers to the mitigation account.

Section 22. Severability.

Section 23 . Effective dates. The advisory committee, coverage expansion, education and outreach, short-term Medicaid delivery system reforms, physician workforce provisions, special revenue accounts, and fund transfer take effect July 1. Other provisions take effect on October 1.

Section 24. Contingent termination. The so-called "circuit breaker," this section specifies that the expansion and special revenue accounts terminate if the federal medical assistance percentage for services provided to the Medicaid expansion population fall below levels set in the Patient Protection and Affordable Care Act.

Section 25. Sunset. The Medicaid expansion and advisory committee provisions would sunset on June 30, 2017.

Prepared by MHA, March 20, 2013.

BILLINGS GAZETTE

Gazette opinion: Covering Montanans: Medicaid must be reformed

MARCH 24, 2013 12:10 AM

The debate this week in Helena about offering Medicaid coverage to Montanans making less than $15,400 a year should be about reform and jobs.

Montana health care providers who serve low-income and uninsured citizens struggle to cover those costs by charging other patients and insurers more, thus pushing up insurance premiums. The system discourages people from getting preventive care and early treatment, forcing many who can't pay to wait until their case is a costly hospital emergency. Patients often must navigate on their own, seeing doctors who don't know the patient's history and unnecessarily duplicate tests.

Montanans who fall through the cracks in our system are mainly adults working for low wages, according to the Montana Budget and Policy Center. Their problems getting timely health care can result in lost work days and lower productivity, too.

A study by the Bureau of Business and Economic Research at the University of Montana as well as U.S. Census Bureau surveys have estimated that about 69,000 Montanans would be newly eligible for Medicaid if it covered everyone whose income is below 138 percent of poverty level.

Gov. Steve Bullock proposes to cover those Montanans. His bill, introduced this month by House Minority Leader Chuck Hunter, includes:

- A circuit breaker that would end the expanded program if federal support dropped below 90 percent of care costs.
- Support for training more doctors in Montana.
- Using the patient-centered medical home model to deliver better and more cost-effective care to Medicaid patients.

In the Senate, Dave Wanzenried, D-Missoula, this week introduced a Medicaid reform bill that incorporates the patient-centered medical home and several other changes to make the program work better for patients while instituting cost-saving measures. Wanzenried's bill was proposed by the Montana Hospital Association, which also represents nonprofit nursing homes and other Montana health care providers.

Montana business and economic development leaders have joined local hospitals, clinics, nurses, doctors and Montana AARP to support extending Medicaid coverage to low-income citizens.

Covering low-income citizens is good for their health and good for the state's economy. The federal funds that would pay for care of the newly eligible will pump up the state

economy, generating jobs in health care and supporting Montana businesses. The BBER estimates that serving 69,000 more Montanans through Medicaid would generate $477 million annually in labor income statewide. Those wages would be spent in every county and increase revenue for local and state governments.

In a letter to members of the House committee that will hold a hearing on the governor's bill on Monday, Billings Chamber of Commerce and Big Sky Economic Development Authority leaders said:

"Currently, there are 7,245 uninsured adults in Yellowstone County who would be eligible for Medicaid if the proposed expansion passes. For Yellowstone County, this expansion has the potential to create over 1,400 jobs and generate approximately $60 million in labor income annually. These are dollars that will primarily be spent in Montana in general and Billings in particular. The total economic impact potentially could be two or three times greater."

We join the chamber and EDA in supporting extending Medicaid coverage with "meaningful cost containment measures that would ensure we get better value for the tax dollars we spend."

Communicate with lawmakers

- House Bill 590, Gov. Steve Bullock's Medicaid proposal, will have a hearing at 3 p.m. Monday in Helena before the House Human Services Committee, which is chaired by David Howard of Park City. Vice chairs are Carolyn Pease-Lopez and Cary Smith of Billings. Dennis Lenz of Billings is a committee member.
- Senate Bill 395, the Montana Hospital Association Medicaid proposal, will have a hearing at 3 p.m. Wednesday in the Capitol by the Senate Public Health Committee chaired by Jason Priest of Red Lodge.
- Constituents who want to communicate with these lawmakers can leave messages by calling 406-444-4800 weekdays or online at the legislative website leg.mt.gov. For a direct link to the online message page, go to this Gazette opinion at billingsgazette.com.
- How much do you know about the Affordable Care Act? Find out by taking an interactive quiz at the link with this Gazette opinion at billingsgazette.com.

Great Falls
DEVELOPMENT
AUTHORITY

March 13, 2013

Representative Hunter
Minority Leader
Montana House of Representatives
PO Box 200400
Helena, MT 59620-0400

RE: Montana Medicaid Expansion

Dear Representative Hunter,

The Great Falls Development Authority's Board of Directors supports the concept of expanding Medicaid in Montana.

GFDA is a public/private economic development partnership serving the 13-county Great Falls trade area. Our mission is to grow and diversify the Great Falls economy and support the creation of high wage jobs.

We support the expansion of Medicaid because it would lead to significant job creation, more cost effective and better health care for Montanan's, and less reliance on employer-paid health insurance to subsidize non-insured. We believe the state should take advantage of the federal offer to expand at this time, with a sunset provision to revisit the expansion in years ahead. Our support is contingent on the promise of federal funding. Should federal funding change, expansion should be re-considered.

Sincerely,

Brett Doney
President & CEO

Great Falls
DEVELOPMENT
AUTHORITY

March 13, 2013

Speaker Blasdel
Montana House of Representatives
PO Box 200400
Helena, MT 59620-0400

RE: Montana Medicaid Expansion

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Sincerely,

Brett Doney
President & CEO

Medicaid expansion makes sense for Montana

By Jason A. Spring | Posted: Saturday, February 23, 2013 10:00 pm

One of the most important issues facing the 2013 Montana Legislature is whether to take advantage of the opportunity to expand health insurance coverage to low-income Montanans who fall in the gap between those eligible for Medicaid and those who typically can afford private insurance.

The administration and board of directors of North Valley Hospital support such an expansion for a variety of reasons.

The need is great. Approximately 69,000 Montanans who are currently uninsured would qualify for health insurance with the expansion allowing them to receive preventative care and early treatment so that they don't delay seeking care until their situation escalates out of control or worse.

Our community hospital sees patients from a wide variety of demographic sectors and is recognizing an increasing number of individuals without health insurance who are generally less healthy than those with some form of coverage. These individuals frequently avoid routine, preventative health screenings and obtain care only when they are very sick. They are more likely to use the hospital emergency room, which is the most expensive venue for care. More serious illness combined with the most costly form of care leads to skyrocketing costs for everyone in the form of higher insurance premiums and hospital costs.

Last fiscal year, North Valley Hospital experienced a 20 percent rise in charity care by providing health-care services to an expanding number of families with income levels meeting our charity care guidelines. Our bad-debt expense also increased 7 percent as more patients without insurance were provided care, but did not or could not pay for services. Higher insurance premiums and higher costs will lead to even more people falling into the coverage gap.

We have recently completed a Joint Community Health Needs Assessment for Flathead County with our partners at Kalispell Regional Healthcare and the Flathead City-County Health Department. The comprehensive research indicates that issues such as preventative health care, mental health and coordination of care, especially for low-income individuals, are significant in our area. Expanding insurance coverage in conjunction with outreach efforts offered by healthcare providers will help address these gaps.

Another benefit of the Medicaid expansion will be the job growth in health-care related positions to serve the families who would become eligible for insured care. The Montana Medical Association cites an estimate of 12,000 new jobs would be created around the state including not only clinical workers, but also support staff from a wide variety of skill areas. The Flathead Valley is poised to respond with hard workers and a world-class learning institution, Flathead Valley Community College, which is expanding its nursing program right in our back yard.

Independent Record

Medicaid expansion benefits businesses

FEBRUARY 11, 2013 11:15 AM • WILLIAM F. WOODY MISSOULA

As owner of a family of multistate businesses employing almost 13,000 people - 1,600 here in Montana — I am a strong supporter of the decision made by states accepting increased federal funding available to expand Medicaid eligibility in 2014. I want to thank Gov. Bullock for including a plan to implement expanded Medicaid eligibility in his proposed budget.

In addition to providing valuable health care coverage to an estimated 60,000 uninsured Montanans, Medicaid expansion directly benefits Montana businesses helping reduce and contain costs incurred for health insurance for employees. States that decide not to expand Medicaid — rejecting federal funds that will pay for most of it — are in essence making a choice to shift future cost of uncompensated health care provided to those who remain uninsured to local businesses in the form of higher premiums. In addition to the impact of uncompensated care, cost of providing employer-sponsored health insurance to employees who would have been Medicaid eligible will be shifted to their employers if Medicaid expansion is not adopted.

I strongly urge the Montana Legislature to support businesses in our state by adopting the governor's Medicaid expansion proposal. It's clearly a policy that will benefit Montana workers and people who employ them.

William F. Woody

Missoula

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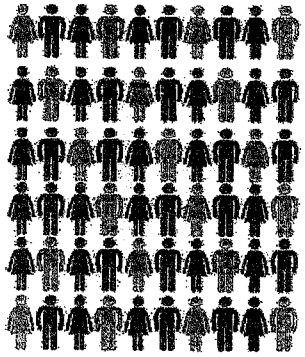
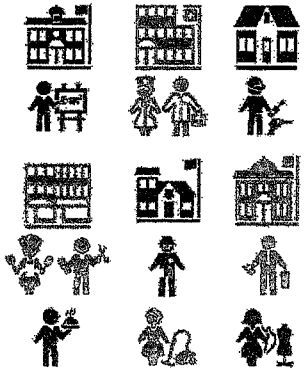
Montana SB 395 2013 legislature

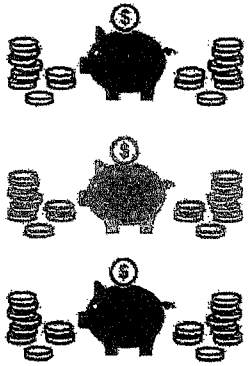
Medicaid Expansion - Big Impacts in Big Sky Country



60,000-
The number of Montanans who gain access to medical care.



14,000-
Jobs created by Medicaid expansion in Montana.



$1.4 Billion-
The increase in statewide earnings after Medicaid expansion.

Source: Bureau of Business and Economic Research at the University of Montana

MONTANA BUDGET & POLICY CENTER

Modernize Montana Medicaid
Liked · February 13

A picture is worth 1,000 words (or in this case, 14,000 #jobs). @senatorripley @votejannataylor #MTLeg #MTPol

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Montana GOP Dentist says it's Time to Modernize Medicaid

Expanding Medicaid helps Montana, GOP

March 04, 2013

Montanans rely on the U.S. government for many things, including significant investment in our roads and bridges, in the federal lands in our state and in our health care system, largely through Medicare and Medicaid. The Montana Legislature is currently considering whether or not to modernize Montana's Medicaid system by green lighting a federal program that will significantly increase the number of federal dollars available to the state of Montana to serve people who need access to health care services.

As a medical professional and as a Republican, I strongly urge Montana's Republican legislators to recognize that the job creation, the economic development and the opportunity to modernize our Medicaid system is sound public policy and good politics for our party. Please stand with other conservative Republicans, including North Dakota Gov. Jack Dalrymple, Ohio Gov. John Kasich, Michigan Gov. Rick Snyder and Arizona Gov. Jan Brewer, in support of legislation to improve Medicaid and increase the number of Montana families served by this important healthcare program.
Please join with your Republican colleagues to take a leadership role to pass this legislation and ensure that it includes important measures that prevent fraud, waste and abuse.

Dr. Jane Gillette, DDS
Bozeman

Independent Record

Bozeman Daily Chronicle Editorial: Medicaid expansion the sensible thing to do for Montana

Posted: Friday, March 1, 2013 9:48 am

The ideological cloud that hangs over ObamaCare has so distorted our understanding of its effects that some of the arguments associated with it have become irrational. How else could it be that Montana Gov. Steve Bullock has to fight push-back against his plan to expand Medicaid at the expense of the federal government?

Let's look at the simple facts: This federal infusion of money will create, by the governor's estimation, 5,000 jobs here in Montana – good-paying health care jobs.

Even more importantly, it will extend health insurance to some 70,000 Montanans – those who earn too much to qualify now for Medicaid now but not enough to afford health insurance on their own.

Montana has more uninsured citizens than the national average. Some 18 percent of state residents are without coverage. And when they suffer injury or illness, they are forced to seek care from emergency rooms – the most expensive point in the health care system. When they can't pay the bill, the cost is foisted on the rest of Montanans in the form of higher insurance premiums.

Expanding Medicaid and accepting the federal funds to do so makes so much sense that even eight Republican governors – some of whom once vowed they never would – have accepted the deal. The plan calls for the federal government to pay 100 percent of the costs of expansion in the first three years and 90 percent thereafter. To pass that up simply makes no sense.

Opposition to this program in Montana is coming from Republicans who argue that the state will be left holding the bag if the feds stop paying into the program entirely in a few years. Bullock has responded with a provision in his proposal that will end the expanded Medicaid eligibility immediately if the federal government ever reneges.

But that won't be enough to squelch all opposition. There are many lawmakers who will oppose the plan simply because it came from a federal administration they will oppose at every turn – no matter how much it harms our state.

Let's hope cooler heads prevail on this one. Expand Medicaid. It's the only sensible thing to do.

CEO of Pondera Medical Center Supports Modernizing Montana Medicaid

Explains that Failure to do so Essentially Results in Double Taxation

March 18, 2013

This letter is in support of modernizing Montana Medicaid. Taking this unprecedented opportunity to reform our Medicaid system enables many Montana citizens who are not covered by any health insurance due to the lack of economic resources that many other citizens take for granted to have the choice to access previously unattainable healthcare coverage.

There has been much said about "over-loading" our medical system if we move forward and choose to extend basic healthcare benefits to some 60,000 lives that are not currently without any form of insurance under the Big Sky. It is also said that this is something that we cannot afford and should not do.

Here are some of my thoughts, as a medical professional, hospital administrator, and former chief operating officer with regards to our opportunity to modernize Medicaid.

Many of the lives that are not covered currently cannot currently purchase any kind of insurance benefit. People without healthcare coverage still get sick and will go to many of our local emergency room departments for treatment. Many of these charges do not get paid and are written off in the form of uncompensated care, costs that are often shifted to members of our community who are insured, resulting in higher procedural costs and insurance premiums. In addition, emergency room care is the most expensive type of healthcare service(s) that are provided in all our communities.

Medicaid modernization would allow individuals to see healthcare providers in their clinics with some type of coverage. Most who are currently not covered will not seek out healthcare until it is emergent and will tend to show up in our emergency rooms. Providing workers access to preventative care results in a healthier, more productive workforce, and therefore, greater economic activity and production across the state.

Furthermore, hospitals are already funding this program through federal law. Medicare and Medicaid payments starting in 2010 were reduced and will continue to be reduced for the next 10 years. This reduction will contribute $400 million to Medicaid modernization across the nation. If Montana chooses to not participate, reductions in Medicaid and Medicare payments will not return to our state. We will essentially pay double for not participating.

Finally, those lives covered under Medicaid modernization do not have significant earnings. At a maximum of 138% of federal poverty guidelines or $15,856 in earnings

this is not a large amount of income to live off of let alone buy health insurance.

Modernizing Medicaid is a good thing for Montana's citizens that work hard but cannot afford health insurance. It is also good for Montana's economy which would benefit from healthcare dollars flowing into the state. Finally, Montana's healthcare industry, citizens, and businesses will benefit from lower healthcare costs and a reduction in cost-shifting.

Sincerely,

Tiffany Nitz, Interim CEO
Pondera Medical Center
Conrad, Montana
(406) 271-3211

Cut the Politics - Remember Everyday Montanans

Wyoming and Montana share many things; a common boarder, a proud agricultural legacy, and a truly rural landscape. As the 2013 Wyoming State Legislature adjourned on 27 February, 2013, it was with great disappointment that efforts to expand Medicaid were not successful. Watching my neighbors in Big Sky Country currently debate modernizing Medicaid I hope you do not fail to reap the full financial benefits of this unique opportunity by failing to act now.

We, in Wyoming, are disappointed to miss out on the first four months of funding, however, we are optimistic the Wyoming legislature will support Medicaid modernization next session [February 2014]. We believe Wyoming will follow other Republican states and make this not a political issue, but an issue about people. We are, after all, the Equality State. Currently Wyoming hospitals are paying for uninsured and uncompensated medical costs, which in turn, affect everyone's insurance costs which is not a sustainable model.

As the owner of a small business which involves large amounts of manual labor, trying to find coverage for all of our employees is of paramount concern in our workplace. Medicaid expansion is a good deal for small businesses, for communities, and for community hospitals. This is the case for Montana just as it is for my home-state of Wyoming.

We must get past the politics and gamesmanship with DC and bring this discussion back to how it affects the everyday members of our communities. In Wyoming the truth is that providing coverage for 17,000 more Wyomingites most of who are the hard-working poor is good for the health of our state, our businesses, and our community as a whole. In Montana, the truth is that providing coverage for more than 60,000 hard-working poor Montanans is, simply put, the right thing to do.

Below is what Wyoming's Business Coalition on Health had to say about this issue. I encourage you, my fellow elected officials, to modernize Montana's Medicaid system. Set politics aside. Remember your constituents. This is the right thing to do.

Daniel Zwonitzer
R – HD 43
521 Cottonwood Drive
Cheyenne, Wyoming 82001

Wyoming Business Coalition on Health
Statement on the Medicaid Expansion
January 2013

As the Wyoming Legislature considers the issue of expanding Medicaid under the provisions of the federal Patient Protection and Affordable Care Act (PPACA), the members of the Wyoming Business Coalition on Health encourage our policy makers to consider approving the Medicaid Expansion program as proposed by the Department of Health.

Department of Health Director Tom Forslund, a respected conservative fiscal manager, has done an internal analysis of the costs and offsets associated with the Medicaid expansion. He has calculated that the State of Wyoming could save $47 million over six years if we do the full expansion. However, if the state only proceeds with the mandatory parts of the expansion, it could cost the state $79 million over the same six years. So adopting the full Medicaid expansion can benefit the citizens of Wyoming in the amount of $126 million.

There is another issue for us as employers who provide healthcare benefits, and that is the hidden tax that directly impacts our cost of doing business. We know that at least one-third of the dollars we pay for health insurance for our employees go to cover the costs of the uninsured. The costs of the services they receive get shifted to us as a hidden tax, and we have no way of knowing just how big that tax is. It is levied in secret, behind the closed doors of every physician, physical therapist, lab and hospital.

Instead of continuing to pay this hidden tax, The Business Coalition on Health believes it would be in everyone's best interest to get these costs out in the open, so they are known. In other words, we would rather have an explicit tax than the current hidden tax.

If Wyoming businesses continue to pay this hidden tax, while businesses in other states do not, then Wyoming businesses are at a competitive disadvantage. To illustrate this point, suppose there is a bid to repair a five-mile stretch of road. If Colorado accepts the federal dollars for the full Medicaid expansion – which it likely will – then Colorado contractors will not be carrying the same hidden tax in their costs as a Wyoming contractor, if Wyoming's legislature turns down the expansion funds. The Wyoming contractor will be at a competitive disadvantage compared to the Colorado contractor due to higher healthcare costs.

We urge Wyoming legislators to recognize that those of us who are providing health insurance benefits for our employees are currently paying for the individuals who would be covered by the Medicaid expansion. Our healthcare costs are higher than they should be because we pay for services for those who are uninsured. This is an issue with far reaching implications for individuals and businesses in Wyoming, and a deeper consideration of the issues is warranted.

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The Supreme Court's ACA Decision and Its Hidden Surprise for Employers

Without Medicaid Expansion, Employers Face Higher Tax Penalties Under ACA

By Brian Haile
Senior Vice President for Health Policy
Jackson Hewitt Tax Service Inc.

March 13, 2012

Key Findings

- States that do not expand Medicaid leave employers exposed to higher "shared responsibility" payments under the Affordable Care Act (ACA).

- The associated costs to employers could total $876 million to $1.3 billion each year in the 22 states that have opposed, are leaning against, or remain undecided about expanding Medicaid. By way of example, the decision in Texas to forego the Medicaid expansion may increase federal tax penalties on Texas employers by $299 to $448 million each year.

- Any projections of the "net" costs of Medicaid expansions should reflect the very real costs of the shared responsibility penalties to employers in any particular state.

Background and Context

While upholding other provisions of the ACA in June 2012, the U.S. Supreme Court ruled that the federal government could not compel states to expand Medicaid for certain low-income adults. Federal and state law prior to the enactment of the ACA limited Medicaid eligibility to very low income persons who are aged, blind, disabled, minor children, pregnant women and parents. Congress attempted under the ACA to force states to expand Medicaid to all categories of low-income adults under age 65 who were at or below 138% of the federal poverty level (FPL).[1] Under the Court's ruling in *NFIB v. Sebelius*,[2] though, states now have the option rather than an effective requirement to expand Medicaid to such adult residents.

Coverage options for low income adult residents may be limited in states that do not expand Medicaid. In drafting the ACA, members of Congress assumed that individuals under 138% FPL would be eligible for the Medicaid expansion. They consequently limited access to the

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[1] § 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. § 1396a) as added by § 2001(a)(1) of the ACA. While this provision references a 133% FPL income limit, a subsequent amendment to § 1902(e)(14)(I) by § 1004(e)(2) of the Health Care and Education Reconciliation Act (HCERA) of 2012 adds an additional five percent income disregard. For reference, the federal poverty level (FPL) is a construct that varies by household size: 138% FPL in 2013 is $15,856 for a household of one and $32,499 for a household of four.

[2] 567 U.S. __ (2012).

premium assistance tax credit programs to eligible individuals between 100% and 400% FPL. In states that do not expand Medicaid, then, otherwise-ineligible persons under 100% FPL will not be eligible for a subsidized coverage option under the ACA. Those between 100% and 138% FPL would be eligible for the premium assistance tax credits, but they will have to pay a monthly premium for coverage through a qualified health plan.[3]

The coverage options are also tied to employer penalties. Employers will generally not face penalties because their employees enroll in Medicaid.[4] Under the "shared responsibility" provisions of the ACA,[5] though, employers that offer health coverage and have 50 or more full-time equivalent employees must generally pay up to $3,000 penalties for each employee who enrolls in the premium assistance tax credits.[6] The "shared responsibility" provision also caps an employer's total liability at approximately $2,000 multiplied by the total number of employees.[7]

Some Governors have expressed concern about the future costs associated with an expansion of Medicaid in their states.[8] While the ACA ensures that the federal government will pay 100% of the costs of the Medicaid expansion through 2016, states the expand Medicaid become responsible for some portion of the costs thereafter (rising to 10% of the total costs in and after

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[3] See FAQ #31 in Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid" (December 10, 2012), available at http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf, accessed on March 1, 2013.

[4] Under § 4980H(a) of the Internal Revenue Code, employers with 50 or more full-time equivalent employees will be liable for employer shared responsibility payments if they do not offer coverage and at least one of their employees is eligible for a premium tax credit. In this sense, employers could face penalties for employees who enroll in Medicaid – but the penalty is unrelated to the employee's enrollment in the Medicaid program and is instead triggered by another employee who enrolled in the tax credit program. Also, see note 14.

[5] § 4980H(b) of the Internal Revenue Code (IRC) as added by § 1513 of the ACA, as amended. See Internal Revenue Service, "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act," December 28, 2012, available at http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act accessed March 1, 2013; Congressional Research Service Report R41159, "Summary of Potential Employer Penalties Under PPACA" (June 2, 2010), available at http://www.ncsl.org/documents/health/EmployerPenalties.pdf, accessed March 1, 2013.

[6] Employees eligible for coverage through their employer may still qualify for the premium assistance tax credits if their employer plan is "unaffordable" in that it costs more than 9.5% of the employee's household income, the plan does not cover the essential health benefit package as defined by HHS, or the plan does not provide "minimum value" (e.g., the plan's deductible and other cost-sharing are too high). § 36B(c)(2)(C) of the IRC as added by § 1501(a) of the ACA, as amended; 77 Fed. Reg. 30377, 30388 (May 23, 2012) (to be codified at 26 CFR § 1-36B-2(c)(3)); 78 Fed. Reg. 7264, 7265 (Feb. 1, 2012) (to be codified at 26 CFR § 1-36B-2(c)). See Congressional Research Service Report R41137, "Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)" (December 30, 2011), available at http://www.tn.gov/nationalhealthreform/forms/CRS11-12-30.pdf, accessed March 1, 2013.

[7] A helpful flow chart in this regard is available from the Kaiser Family Foundation at http://healthreform.kff.org/the-basics/employer-penalty-flowchart.aspx. Note that employers that do not offer coverage are subject to a different set of related penalties under § 4980H(a) of the Internal Revenue Code; however, the proportion of employees working at such firms is relatively low. See note 14.

[8] See, e.g., Letter from Governor Bob McDonnell of Republican Governors Association to President Barak Obama (July 10, 2012), available at http://www.rga.org/homepage/rga-letter-on-medicaid-and-exchanges-to-president-obama/, accessed on March 1, 2013.

2020).[9] These costs have generated substantial discussion among state policy-makers as to the feasibility of such expansions of the Medicaid program.[10]

Paradoxically, state government efforts to constrain Medicaid costs growth in and after 2017 may lead to higher net taxes for employers in such jurisdictions beginning in 2014. If a state foregoes the Medicaid expansion, then eligible employees between 100-138% FPL may enroll in the premium assistance tax credits. In such circumstances, their employers will face liabilities for the "shared responsibility" tax penalties discussed above.[11]

Methods

We used data from Current Population Survey 2011-12 from the U.S. Census Bureau to estimate the number of uninsured adults working full-time under age 65 by state who are between 100-150% FPL. To estimate the number of such individuals who may be eligible to enroll in the premium tax credit programs, we assumed that:

- Persons between 100% FPL and 150% FPL are equally distributed (i.e., they are equally likely to be at 124% FPL as 139% FPL);[12]
- 46% of uninsured individuals who are employed full-time and earn between 100-138% FPL work for companies with 50 or more employees;[13] and
- 91% of the firms at which these employees work would offer some form of health coverage.[14]

Results

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[9] § 1905(y) of the Social Security Act (42 U.S.C. 1396d) as added by § 2001(a)(3)(B) of the ACA and amended by § 1201(1)(B) of the HCERA.

[10] See, e.g., Bovbjerg, Randall, Barbara A. Ormond, and Vicki Chen, "State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts," Kaiser Family Foundation Issue Brief, February 2011, available at http://www.kff.org/healthreform/8149.cfm, accessed March 1, 2013.

[11] See e.g., Radnofsky, Louise, "In Medicaid, a New Health-Care Fight," *Wall Street Journal*, February 11, 2013, p. A1; Millman, Jason, "Lack of Medicaid expansion could penalize employers," *Politico*, August 29, 2012.

[12] Using this assumption, the proportion of the population below between 100% FPL and 138% FPL would be represented as: # uninsured, full-time employed between 100-150% FPL * (138-100) / (150-100).

[13] Avalere Health analysis of the Current Population Survey, Annual Social and Economic Supplement, United States Census Bureau, 2012.

[14] Among employees that work at firms with 50+ employees that also have a majority of low-wage workers, 91.4% work at firms that offer health coverage. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey-Insurance Component, Table I.B.2(2011): Percent of private-sector employees in establishments that offer health insurance by firm size and selected characteristics: United States, 2011available at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1&year=2011&tableSeries=1&tableSubSeries=B&searchText=&searchMethod=1 accessed March 6, 2013. Employers that offer health coverage would not be subject to broader penalties under § 4980H(a) of the Internal Revenue Code, but they would be subject to penalties for a smaller subset of employees under § 4980H(b).

Applying these assumptions to these data, we estimate that approximately 1.01 million full-time uninsured employees under age 65 could enroll in the premium assistance tax credits. If 100% of such employees were to enroll and no state were to expand Medicaid, the collective employer liability each year for the shared responsibility payments would be between $2.03 and $3.04 billion dollars.

Clearly, though, some states are expanding Medicaid. Indeed, the Advisory Board estimates that 24 states and the District of Columbia have moved forward with such expansions, and an additional four states are leaning towards expanding Medicaid. In contrast, 14 states are not expanding Medicaid, while three states are leaning against and another five states are undecided about such expansions.[15] If the 22 opposed and undecided states were to reject the Medicaid expansion and the eligible employees between 100-138% FPL were to enroll in the tax credits, then employers in those jurisdictions may incur liabilities for the shared responsibility penalties of up to $876 million to $1.31 billion each year. For reference, we shaded these "expansion averse" or undecided jurisdictions in Table 1 below. Please note, however, that some Governors may have indicated a willingness to expand Medicaid but have not yet received the required legislative authorization (e.g. Florida).

Table 1: Potential Employer Tax Penalties by State

State	100-138% FPL	Eligible for APTCs	Expansion Plans	Potential Employer Shared Responsibility Liabilities *(Assuming $2,000 to $3,000 per employee)*		
US	2,420,017	1,013,019		$ 2,026,038,299	to	$ 3,039,057,449
AL	35,429	14,831	No	29,661,092	to	44,491,638
AK	5,288	2,214	Leaning against	4,427,181	to	6,640,771
AZ	54,272	22,718	Yes	45,436,820	to	68,155,230
AR	30,541	12,784	Yes	25,568,590	to	38,352,885
CA	350,377	146,668	Yes	293,335,390	to	440,003,085
CO	32,045	13,414	Yes	26,827,773	to	40,241,659
CT	10,814	4,527	Yes	9,053,514	to	13,580,271
DE	3,905	1,635	Yes	3,269,166	to	4,903,748
DC	1,689	707	Yes	1,413,796	to	2,120,695
FL	174,075	72,868	Yes	145,735,557	to	218,603,335
GA	85,619	35,840	No	71,680,495	to	107,520,742
HI	3,874	1,622	Yes	3,243,078	to	4,864,618
ID	14,724	6,164	No	12,327,134	to	18,490,701
IL	84,291	35,284	Yes	70,568,291	to	105,852,437
IN	43,632	18,265	Undecided	36,529,012	to	54,793,518
IA	15,241	6,380	No	12,759,799	to	19,139,698
KS	19,407	8,124	Undecided	16,247,206	to	24,370,808
KY	38,611	16,163	Leaning toward	32,325,163	to	48,487,744
LA	61,780	25,861	No	51,722,551	to	77,583,826

[15] The Advisory Board Company, "Where each state stands on ACA's Medicaid expansion: A roundup of what each state's leadership has said about their Medicaid plans," available at http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1/, accessed March 6, 2013.

State	100-138% FPL	Eligible for APTCs	Expansion Plans	Potential Employer Shared Responsibility Liabilities *(Assuming $2,000 to $3,000 per employee)*		
ME	4,170	1,746	No	3,491,224	to	5,236,837
MD	29,874	12,505	Yes	25,010,580	to	37,515,870
MA	6,885	2,882	Yes	5,763,988	to	8,645,982
MI	64,591	27,038	Yes	54,075,485	to	81,113,227
MN	21,250	8,895	Yes	17,790,165	to	26,685,248
MS	25,966	10,869	No	21,738,869	to	32,608,304
MO	39,867	16,688	Yes	33,376,920	to	50,065,380
MT	11,951	5,003	Yes	10,005,377	to	15,008,066
NE	11,744	4,916	Leaning against	9,832,311	to	14,748,467
NV	21,467	8,986	Yes	17,972,139	to	26,958,208
NH	4,328	1,812	Yes	3,623,569	to	5,435,354
NJ	53,597	22,436	Yes	44,871,810	to	67,307,715
NM	16,751	7,012	Yes	14,024,071	to	21,036,107
NY	110,962	46,449	Leaning toward	92,897,621	to	139,346,431
NC	78,315	32,783	No	65,565,285	to	98,347,927
ND	3,400	1,423	Yes	2,846,681	to	4,270,021
OH	70,441	29,487	Yes	58,973,507	to	88,460,260
OK	41,909	17,543	No	35,085,947	to	52,628,920
OR	26,421	11,060	Leaning toward	22,119,360	to	33,179,040
PA	67,708	28,342	No	56,684,836	to	85,027,254
RI	4,543	1,901	Yes	3,802,998	to	5,704,497
SC	36,368	15,223	No	30,446,888	to	45,670,332
SD	6,469	2,708	No	5,415,947	to	8,123,921
TN	71,153	29,785	Undecided	59,569,693	to	89,354,540
TX	356,627	149,284	No	298,568,091	to	447,852,136
UT	18,527	7,756	Undecided	15,511,039	to	23,266,558
VT	2,355	986	Yes	1,971,807	to	2,957,710
VA	49,917	20,895	Leaning toward	41,790,345	to	62,685,517
WA	50,594	21,179	Yes	42,357,263	to	63,535,895
WV	14,217	5,951	Undecided	11,902,740	to	17,854,110
WI	28,752	12,036	No	24,071,442	to	36,107,163
WY	3,285	1,375	Leaning against	2,749,968	to	4,124,951

Discussion

Our goal was to estimate the order of magnitude of the potential employer liabilities by state. While we acknowledge that data limitations require us to make simplifying analytical assumptions that affect the specific point estimates reported above, we believe these results to be directionally correct.

We have been relatively conservative in our assumptions, though we understand that policy-makers may want to refine the estimates with state-specific data that they may have at their disposal but which are not freely available to the public. For precisely this reason, we have attempted to be fully transparent about our methods.

The actual liabilities that employers incur will depend on the "uptake" or participation rates among eligible employees in the new premium assistance tax credit programs offered through the new insurance exchanges. Because we seek to quantify the potential liability, though, we do not adjust our estimates for estimates of participation rates (which vary widely among experts).

This analysis explicitly excludes employees who are currently insured. Data from the Current Population Survey in 2011-12 suggest that some 2.4 million adults are age 19-64, working full-time, are between 100-150% FPL, and have employer-sponsored health insurance. It is unclear how many of these individuals may drop coverage and migrate to the exchanges and the premium assistance tax credit programs. If this phenomenon were to become widespread, the potential shared responsibility payment liabilities for employers would only increase.

For the reasons discussed above, states that expand Medicaid may effectively lower the penalties for employers that do not provide health coverage. A state's decision to expand Medicaid, though, is unlikely to have a material effect an employer's incentive to provide employee coverage for several reasons.[16] We acknowledge, though, that Medicaid expansions could theoretically alter the employer's calculus in the provision of health coverage – and policy-makers should at least be aware of this issue.

Conclusion

These estimates suggest that employer liabilities for the shared responsibility payments may be substantial. Such costs could exceed $1 billion across those states that are now facing the decision about whether to expand Medicaid or that have thus far declined to do so. Any projections of the "net" costs of Medicaid expansions should reflect the very real costs of such liabilities to employers in any particular state.

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[16] We believe this to be true for several reasons. First, employer plans cover a much broader group of employees than just those 100-138% FPL. Second, the employer's tax benefits for providing compensation in the form of health benefits remain intact. Third, an employer may not be able to accurately forecast the effect of the Medicaid expansion on the firm because the employer lacks complete information about each employee's household size and income (and cannot therefore estimate the number of employees who fall between 100% and 138% FPL).

2012 Montana Hospital Report Card

Summary Results:			
Excellent	Good	Fair	Poor

Category: Quality (Better Care for Individuals)

Metric	Montana	U.S.	MT Rank	Source
30-Day Readmission Rates - Heart Failure	22.5%	24.8%	2 of 51	CMS Hospital Compare (Medicare)
30-Day Readmission Rates - Heart Attack	18.2%	19.8%	5 of 51	CMS Hospital Compare (Medicare)
30-Day Readmission Rates - Pneumonia	17.4%	18.4%	7 of 51	CMS Hospital Compare (Medicare)
30-Day Mortality Rates - Heart Attack	14.50%	15.9%	8 of 51	CMS Hospital Compare (Medicare)
Surgical Care Improvement Composite	97.7%	97.4%	13	CMS Hospital Compare (Medicare)
Heart Attack Composite	98.5%	98.2%	16	CMS Hospital Compare (Medicare)
30-Day Mortality Rates - Pneumonia	12.10%	11.9%	25 of 51	CMS Hospital Compare (Medicare)
HCAHPS Patient Satisfaction (Composite)	69.4%	70.6%	35	CMS Hospital Compare (Medicare)
Pneumonia Composite	94.6%	95.7%	40	CMS Hospital Compare (Medicare)
30-Day Mortality Rates - Heart Failure	12.40%	11.3%	43 of 51	CMS Hospital Compare (Medicare)
Heart Failure Composite	90.4%	95.9%	49	CMS Hospital Compare (Medicare)

Category: Community Health Status (Better Health for Populations)

Metric	Montana	U.S.	MT Rank	Source
Percent of Adults Who are Obese	23.5%	27.5%	6	2011 America's Health Rankings
Diabetes (percent of adults)	7.0%	8.7%	7	2011 America's Health Rankings
Hospital Outpatient Visits (per 1,000 pop.)	3,575.30	1,217.30	8	AHA Annual Survey
Air Pollution (Micrograms per cubic meter)	7.7	10.8	9	2011 America's Health Rankings
Hospital Admissions (per 1,000 pop.)	98	114	15	Henry J. Kaiser Family Foundation
Preventable Hospitalizations (per 1,000 Mcare enrollees)	60.8		18	2011 America's Health Rankings
Infant Mortality (per 1,000 live births)	6.6	7	22	2011 America's Health Rankings
Overall Health Ranking	n/a	n/a	25	2011 America's Health Rankings
Infectious Diseases (per 100,000 pop.)	8.5	10.3	26	2011 America's Health Rankings
Percent of Adults Who Smoke	18.8%	17.2%	32	2011 America's Health Rankings
Lack of Health Insurance	16.6%	16.2%	34	2011 America's Health Rankings
Binge Drinking (Percent Adults Populations)	17.2%	15.1%	36	2011 America's Health Rankings
Cholesterol Checks	72.0%		45	2011 America's Health Rankings
Dental Visits, Annual	61.1%		46	2011 America's Health Rankings
Immunization Coverage (Children)	83.3%	90%	50	2011 America's Health Rankings

Category: Finacial (Better Value for All)

Metric	Montana	U.S.	MT Rank	Source
Hospital Outpatient Charges per Visit	$700	$1,362	51	AHA Annual Survey - 2010
Hospital Inpatient Charges per Pt. Day	$2,416	$6,460	51	AHA Annual Survey - 2010
Medicare Spending per Enrollee	$7,576	$10,365	51	CMS Health Expenditures by State of Residence
Medicare Reimbursements per Enrollee	$7,576	$10,365	51	Urban Institute & Kaiser Commission on Medicaid
Hospital Expenses per Patient Days	$1,190	$1,910	48	AHA Annual Survey - 2010
Total Medicare Reimburse per Enrollee	$6,518	$8,682	47	The Dartmouth Atlas of Healthcare--2007
Medicare Part A Reimburse per Enrollees	$3,315	$4,716	46	The Dartmouth Atlas of Healthcare--2007
Medicare Part B Reimburse per Enrollee	$3,202	$3,965	42	The Dartmouth Atlas of Healthcare--2007
Health Spending per Capita	$6,640	$6,815	32	CMS Health Expenditures by State of Residence